

**VASCULAR ASSOCIATES
OF CONNECTICUT, L.L.C.**

MEDICAL HISTORY FORM

Date: _____

Name: _____

Reason for Appointment: _____

Age _____ Height _____ Weight _____

Medications include any over the counter medications with dosage and frequency

Allergies

Social History

Occupation: _____

Do you drink alcohol? ___ Yes ___ No Amount per day: _____

Do you smoke? ___ Yes ___ No Amount per day: _____

Prior Surgery

Family History

Have you or anyone in your family been diagnosis with:

Diabetes	___ Yes	___ No	Whom: _____
Hypertension	___ Yes	___ No	Whom: _____
Heart Disease	___ Yes	___ No	Whom: _____
Cancer	___ Yes	___ No	Whom: _____
Stroke	___ Yes	___ No	Whom: _____
Aneurysm	___ Yes	___ No	Whom: _____
Kidney Failure	___ Yes	___ No	Whom: _____
Prostate Cancer	___ Yes	___ No	Whom: _____
Kidney Cancer	___ Yes	___ No	Whom: _____
Bladder Cancer	___ Yes	___ No	Whom: _____
Colon Cancer	___ Yes	___ No	Whom: _____
Breast Cancer	___ Yes	___ No	Whom: _____
Pancreatic Cancer	___ Yes	___ No	Whom: _____
Ovarian Cancer	___ Yes	___ No	Whom: _____
Lung Cancer	___ Yes	___ No	Whom: _____

Continue on back

Have you ever been diagnosed with any of the following conditions
Indicate with Y or N

Cardiovascular

Heart Attack _____
High Blood Pressure _____
Irregular Heartbeat _____
Heart Failure _____
High Cholesterol _____

Aneurysm _____
Shortness of breath _____
Ankle Swelling _____
Chest pain with Exertion _____

Respiratory

Emphysema _____
Pulmonary Embolism _____
Asthma _____

Tuberculosis _____
Chronic Cough _____
Wheezing _____

Gastrointestinal

Hepatitis _____
Diverticulitis _____
Gallstones _____

Jaundice _____
Peptic Ulcer _____

Genitourinary

Kidney Stones _____
Kidney Failure _____

Difficulty Urinating _____
Painful Urination _____

Hematological

Hemophilia _____
Blood Clots _____
Lymphoma _____
AIDS _____
DVT _____

Phlebitis _____
Leukemia _____
Bleeding Disorder _____
Bruise Easily _____
Prolonged Bleeding _____

Endocrine

Diabetes _____
Thyroid _____
Parathyroid _____
Pituitary _____

Excessive Thirst _____
Night Sweats _____
Adrenal _____

Neurological

Stroke _____
Neuritis _____
Epilepsy _____
Sciatica _____
Alzheimer's _____

Loss of Memory _____
Tingling _____
Numbness _____
Paralysis _____
TIA _____

Musculoskeletal

Arthritis _____
Disc Disease _____
Lyme Disease _____

Back Pain _____
Bone Pain _____
Chronic Muscle Ache/Pain _____

Skin

Recent / Chronic Rashes _____
Hives _____
Non Healing Ulcers _____

Eyes
Visual Disturbance _____
Glaucoma _____
Cataract _____

General

Fevers _____
Chills _____
Weight Loss/Gain _____
Difficulty Sleeping _____

Psychological
Depression _____
Irritability _____
Bipolar _____
Substance Abuse _____

Reviewed by: _____

Date: _____